



**GLOBAL EVALUATION
OF USAID'S
POSTABORTION CARE PROGRAM**

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ACRONYMS

ACNM	American College of Nurse-Midwives
ANE	Bureau for Asia and the Near East
CA	Cooperating agency
CDC	U.S. Centers for Disease Control and Prevention
CPR	Contraceptive prevalence rate
CRHCS	Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa
D&C	Dilation and curettage
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
E&E	Bureau for Europe and Eurasia
EOC	Emergency obstetric care
ESA	East and Southern Africa
FCI	Family Care International (in Kenya)
FHI	Family Health International
FP	Family planning
FY	Fiscal year
G/PHN	Bureau for Global Programs, Field Support and Research, Center for Population, Health and Nutrition
GTZ	German Technical Cooperation
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HM/HC	Healthy Mother/Healthy Child Project
ICPD	International Conference on Population and Development, Cairo (1994)
IEC	Information, education and communication
INTRAH	Program for International Training in Health
ISO	International Standards Organization
IUD	Intrauterine device
JHU/CCP	Johns Hopkins University/Center for Communication Programs
JSI	John Snow, International
LAC	Bureau for Latin America and the Caribbean
MCH	Maternal and child health
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MSH	Management Sciences for Health
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
NNAK	National Nursing Association of Kenya
OJT	On-the-job training
PAC	Postabortion care
PATH	Program for Appropriate Technology in Health
PHN	Population, health, and nutrition
PVO	Private voluntary organization
REDSO/ESA	USAID Regional Economic Development Services Office for East and Southern Africa
RH	Reproductive health
RTI	Respiratory tract infection
Sida	Swedish International Development Cooperation Agency
SPA	Service Provision Assessment Survey (Kenya 1999)
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

A global evaluation of the U.S. Agency for International Development's (USAID) postabortion care (PAC) program was conducted in the fall of 2001 to serve as a thorough review of programmatic and technical strengths and challenges. It was conducted at the request of USAID/Washington in order to strengthen its global PAC program. The full report includes case studies of PAC in four countries: Bolivia, Kenya, Ghana, and Nepal.

Most societies have provided some care to women suffering from the complications of abortion, whether induced or spontaneous. In recent years, however, the international reproductive health community has recognized the tremendous mortality and morbidity that results from abortion complications and has resolved to reduce it, on a global basis. The turning point was the 1994 International Conference on Population and Development (ICPD), at which governments, nongovernmental organizations (NGOs), and individuals affirmed, "all countries should strive to make accessible through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible." Prevention of abortion and the management of the consequences of abortion were among the reproductive health care services specifically identified. Most recently, in January 2001, the Bush Administration released a statement in strong support of postabortion care programs.

Since 1990, when USAID funding for PAC programming began, the Agency has had remarkable success, with relatively limited funding. USAID/Washington support for PAC, coming from both the family planning/reproductive health and safe motherhood programs, has been about \$20 million; \$15 million represents spending in the past two years. There are now PAC programs in Africa, Latin America and the Caribbean, Europe and Eurasia, and Asia and the Near East. USAID has worked through its cooperating agencies (CAs), which have effectively used USAID's funding and leadership to leverage funding from foundations as well as bilateral and multilateral donors. Together, the international community has initiated PAC activities in more than 40 countries. Over a quarter of all countries with populations over 2 million have some USAID-funded PAC activities. Striking progress has been made in starting PAC activities in most regions with a high burden of mortality from unsafe abortion.

The PAC program has three elements:

- emergency treatment for complications of spontaneous or induced abortion,
- postabortion family planning counseling and services, and
- linkages between emergency care and other reproductive health services, for example, management of sexually transmitted infections (STIs).

Success to date is greatest in the first component: treatment of abortion complications. In those countries with PAC programs—in hospitals, clinics, and small maternity facilities at the community level—women are receiving treatment through manual vacuum

aspiration (MVA), which is safer and less costly for both the woman and the health facility than traditional dilation and curettage (D&C). One important innovation in the process has been the demonstration in a number of countries that trained nurse-midwives can provide high-quality treatment, thus expanding access to the community level. The benefits of expanding such access were observed in both Ghana and Kenya.

In Kenya, evidence was available for declines in hospital admissions for abortion complications and for declines in hospital maternal mortality. Moreover, the rapid decline in maternal mortality during 1995–99 in the chief teaching hospital in Nairobi suggests that the reduced complications from abortion have facilitated redirecting resources to the prevention of obstetric deaths from other causes. In other countries, the contributions of PAC, other efforts to prevent unintended pregnancy, and changes in health care services have led to reductions in maternal mortality in hospitals, reduced frequency of hospitalizations for severe complications from abortion, and reduced demand for postabortion care. In Kenya, Ghana, and Bolivia, abortion appears to be a declining contributor to the total morbidity of women.

While many of the programs were begun as pilot studies, most countries are in the process of scaling up. The process of initiating and developing PAC was different in each country, depending upon the country context. In some countries, PAC is a public sector program, while in others it is multisectoral. In some countries, treatment of complications is the responsibility of tertiary facilities; in other countries, treatment is occurring at the primary level in communities. Regardless of the country context, however, PAC managers and providers and the CAs that have worked with them have sought to expand access to services. There are notable successes:

- Bolivia has incorporated PAC into its national health insurance program, thus removing financial barriers.
- Mexico and Egypt have sponsored operations research to understand and reduce the social and cultural barriers that lead women to delay seeking help and treatment.
- Many countries, using operations research data, have trained providers to be more compassionate than they had been, using materials produced by USAID's CAs.

The second component of PAC—family planning counseling and services—is not as strong as the first component and needs to be strengthened. PAC family planning counseling and services is dependent upon the maturity of the national family planning program. In countries with strong programs, there are trained providers; extensive information, education and communication (IEC); good contraceptive logistics; and high demand, all facilitating the development of this PAC component. Few countries have such a program, however, and developing strong PAC family planning counseling and services entails reinforcing clinical training in family planning, improving counseling and IEC, and ensuring that a broad method choice is available to women after emergency treatment. All four countries visited by the evaluation team need to strengthen their PAC family planning.

The third component—linkages with other reproductive health services—is very weak. In general, while there are limited examples of attempts to link with other services, this component has received insufficient attention in protocols, training, implementation, and monitoring. Like the second component—family planning—the third component is dependent upon the national reproductive health program. In circumstances where other reproductive health services, such as diagnosis and treatment of STIs, are very poor or unavailable, linkages are difficult, if not futile. The Ghana case study (presented in an appendix to the full report) demonstrates the challenge involved in establishing effective linkages. The Kenyan case study illustrates the importance of doing so in a country with a high prevalence of human immunodeficiency virus (HIV). USAID should define what this component realistically should comprise, in differing country contexts.

PAC programs face considerable challenges, such as the following:

- There is a critical need for data for efficient and effective planning and for assessing impact. Data are necessary for demonstrating the unique contribution of PAC on maternal morbidity and mortality—a demonstration that is increasingly important given the high opportunity costs of any program in developing countries.
- Many countries with a high burden of mortality have no PAC activities. In no country have PAC activities been shown to have reached the majority of the population.
- The community and community demand for high-quality postabortion care will be the basis of PAC sustainability. To date, however, PAC has been largely a medical model. Further work needs to be undertaken to generate understanding and demand for PAC at the community level.

RECOMMENDATIONS

Comprehensive Postabortion Care

Managers should ensure that PAC programs start with a conceptualization of comprehensive PAC for all women treated for complications from spontaneous or induced abortion and should address the attitudinal and organizational issues that lead to separate treatment for MVA and D&C patients.

PAC programs should devote more attention in training, monitoring, and supervision to ensure high-quality family planning:

- knowledge, attitude and skills in family planning (FP),
- organization of FP services (physical location and space),
- counseling,
- IEC materials,
- contraceptive supply and method mix,
- privacy, and
- integration with providers of emergency care.

USAID should fund operations research to determine feasible, acceptable, and effective ways to provide linkages to appropriate reproductive health services.

PAC planners and managers should encourage efforts to work with, educate, and involve the community.

PAC planners, managers, and providers should create partnerships with national and international PVOs and NGOs with expertise in working with communities and maternal and child health (MCH) programs to strengthen PAC programs.

Accessibility

USAID should fund operations research on the most effective ways to expand access to adolescents.

Country PAC managers should carefully analyze key country data and establish objectives, strategies, and indicators for expanding and maximizing geographic access.

PAC planners should specify clear national objectives for PAC (e.g., prevent abortion mortality, prevent need for hospitalization from complications from abortion, prevent repeat abortions through contraception) and set up appropriate surveillance or research to determine whether the objectives are being achieved.

PAC planners and managers should analyze further currently available data, such as Kenyatta and other hospital data, to determine trends in abortion mortality in hospitals and trends in where women live who continue to require hospitalization for abortion complications. Are there PAC services in the communities from which these women come?

Organization of Services

Comprehensive PAC preservice training for all cadres of health care providers (physicians, nurses, clinical officers) should be considered a priority for USAID and CAs.

PAC country programs should attempt to designate model clinical sites with high PAC caseloads for regional training centers to ensure clinical mastery of important PAC clinical skills.

Increased programmatic efforts should be made to find ways to provide PAC services 24 hours a day, 7 days a week.

USAID and CAs should continue to identify effective methods to motivate and encourage both providers and managers to ensure that adequate family planning and other important reproductive health (RH) services are routinely offered as an integral part of PAC.

Quality of Care

The routine sensitization of providers, facility managers, and other staff as well as community leaders and other stakeholders to increase support for the compassionate treatment of PAC clients should be seen as a priority and as the first step in all PAC programs (as much of a priority as MVA and other technical training).

The importance of changing poor and often punitive provider attitudes toward women seeking postabortion care should continue to be emphasized in PAC programs.

USAID should fund high-quality research on pain management, including the need to reduce pain, best methods to reduce pain, and the costs and logistics of reducing pain.

USAID should support the clarification of existing guidelines on pain management for women with bleeding in early pregnancy receiving MVA. At a minimum, the World Health Organization (WHO) guidelines should be promoted: “Provide emotional support and encouragement and give paracetamol 30 minutes prior to procedure. Rarely, a paracervical block may be needed.” Postprocedure care, according to WHO, should be: “Give paracetamol 500 mg by mouth as needed.”

Sustainability

Countries without a strategic plan for national scale up should develop such a plan.

USAID should continue to provide leadership from Washington and the Missions and to promote dedicated PAC staff within governments, CAs, and donors.



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